

**Virginia Perinatal Hepatitis B Prevention (VPHBP) Program  
Infant Information Form**

**PLEASE REPORT ONLY BABIES BORN TO HBsAg POSITIVE MOTHERS**

*(Please include copy of lab slip)*

Mother's Case No. \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_  
Last First Middle

**Father's Name:** \_\_\_\_\_  
Last First Middle

**Mother's Address:** \_\_\_\_\_  
\_\_\_\_\_ **Phone No:** \_\_\_\_\_

**Name and Address of Physician Who Will Provide Care to Infant After Hospital Discharge:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone No: \_\_\_\_\_

**Infant Information:**

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Sex: Male ( ) Female: ( )

**Vaccine Information:**

HBIG Given: Yes ( ) No ( )      Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

How many **hours** after birth was HBIG given? \_\_\_\_\_ hours

HBV1 Given: Yes ( ) No ( )      Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

How many **hours** after birth was the first dose of hepatitis B vaccine given? \_\_\_\_\_ hours

**Mother's HBsAg Status on  
Admission for Delivery**

**Known** ☐

**Unknown** ☐

**No Prenatal Care** ☐

Name of Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Would you like HBIG and hepatitis B vaccine shipped to you to replace the HBIG and vaccine given to this infant?

( ) **Yes**, please replace the HBIG and hepatitis B vaccine given to the above named infant.

( ) **No**, replacement HBIG and hepatitis B vaccine is not necessary.

Form completed by: (Please Print)

\_\_\_\_\_

Phone #: \_\_\_\_\_

**PLEASE RETURN FORM TO:**

Marie Krauss, VPHBP Program Manager  
Virginia Dept of Health  
Division of Immunization - Room 314- West  
P.O. Box 2448  
Richmond, Virginia 23218  
Phone: 1-800-568-1929; Fax: (804) 864-8089